Montana Medicaid Claim Jumper

Provider Medicaid Number Policy

Providers are no longer required to have separate Medicaid numbers for each location where they practice. Providers who practice at several locations, but who operate under one tax identification number, are allowed to use one Medicaid number for all locations.

Providers may still elect to have multiple Medicaid numbers for each site under one tax identification number. However, providers must have a Medicaid number assigned to each tax identification number and must have a Medicaid number for each provider type.

The following providers included in this policy are: physicians, mid-level practitioners, podiatrists, optometrists, audiologists, hearing aide providers, durable medical equipment providers, ambulatory surgical centers, dentists, freestanding dialysis clinics, physical, occupational and speech therapists, pharmacists, EPSDT providers, private nursing providers, nutritionists and QMB chiropractors.

If providers are part of a corporation, each time the corporation receives new ownership, the providers will need to get new Medicaid numbers under the corporation's new tax identification number.

If a provider decides to use one Medicaid number, they can designate which Medicaid number to keep. Letters of termination for the other provider numbers need to be sent to ACS Provider Relations. These letters must have an original signature.

Note: If you are a PASSPORT provider with Medicaid numbers at several sites and would like to start using one Medicaid number, please call the PASSPORT To Health Program at 1-800-480-6823 to make sure the change does not affect your PASSPORT number.

HIPAA Montana Conference

In May 2002 the Montana payer community gathered in Helena and initiated a caucus focused on helping providers, health plans, clearinghouses, and state government agencies impacted by HIPAA. In cooperation with Health-e-Web and Blue Cross and Blue Shield of Montana, a wide cross-section of the health community was represented, including the Montana Medical Association, New West Health Services, Intermountain Administrators, ACS State Healthcare, Department of Public Health & Human Services, Medicare and Medicaid.

During the first caucus, the group discussed the monumental burden and task of HIPAA implementation and decided to focus cooperative energy on provider education. Since that time, members from each of the constituents represented have been meeting almost weekly in an effort to create a statewide cooperative education plan.

This cooperative education plan includes two branches of provider education at this time. The first branch is a cooperative web site (www.HIPAAMontana.com), which is the central repository for HIPAA information, training announcements, conferences and links to other HIPAA related sites. The name of this web site gave the group its name – now called HIPAAMontana. This web site will be up for some time to come, continuing to be providers' link to updated information on HIPAA. This web site has been designed to allow providers to begin their search for information in one standard place, and then be able to filter out incorrect information.

After spending several weeks researching HIPAA information and reviewing "tool kits" from several different consulting/law firms, the group began to focus on two or three of the best offerings. HIPAAMontana presented two workshops in October, in Helena and in Billings, to give providers a chance to preview these tool kits. These workshop days were well attended, and gave many providers a chance to gather HIPAA information.

If you were not able to attend these workshops, the HIPAAMontana group is intending to create additional workshops for providers. Visit the HIPAAMontana site on a regular basis, not only to learn about the workshops, but to keep current on HIPAA information.

Watch for additional Claim Jumper issues to come in 2003!!

Beginning with this issue, we will be distributing the Claim Jumper on a monthly basis. This will help reduce the number of disparate publications the Department mails on a regular basis while still providing up-to-date information. All current manuals and notices are posted on the Provider Information website. If you do not have Internet access, contact Provider Relations.

Suggestions for Chiropractic Claims

We have recently identified several chiropractic claims that were denied for various reasons. We encourage chiropractic providers to review the following guidelines for billing chiropractic services.

Medicaid pays for chiropractic care only for children 0-20 years of age and for Qualified Medicare Beneficiary (QMB) individuals. Even if a Medicaid client has a prescription for chiropractic care, if the client does not meet the requirements above, they are not covered for chiropractic care.

If a child is enrolled in the PASSPORT To Health Program, they must have their PASSPORT provider's approval to receive chiropractic care, even if they have a prescription from a medical provider other than their PASSPORT provider. PASSPORT approval should be obtained before the service is rendered and the PASSPORT approval number must be entered in box 17a of the CMS-1500 form.

If a client is QMB eligible, make sure to verify QMB eligibility before services are rendered. The Explanation of Medicare Benefits (EOMB) must be attached to the claim.

In general, make sure the procedure codes you are billing are valid and active procedure codes. Make sure the date billed entered on the claim is after the services were provided, avoid sending exact duplicates, and verify eligibility before services are rendered. Please remember to bill with your EPSDT provider number when billing for services provided to children and to bill with your QMB Medicaid number when billing for services provided to your QMB clients.

If you need further assistance with chiropractic billing, please contact Provider Relations at the number on the back cover of this publication.

New Policy Change Distribution Procedure

Beginning with the February Claim Jumper, Medicaid policy and procedure changes will be distributed in the monthly Claim Jumper. In the next issue there will be a section titled *Program Updates and Changes*, which will give brief summaries of policy and procedure changes. These updates are published in their entirety on the Provider Information website under *Notices and Replacement Pages*, and providers will be instructed to download and print the notices to file in their provider manuals. Providers who do not have Internet access may contact Provider Relations.

December 20, 2002 Medicaid Program Changes

Important Medicaid reimbursement and program coverage changes are documented on the website at ***http://www.dphhs.state.mt.us***; select *Medicaid Program Changes (Dec. 20, 2002)*. Providers who do not have Internet access may contact Provider Relations.

TPL Tips

If your claim is denied by the primary insurance for a Medicaid client, please keep in mind that we must have the **explanation** of the reason codes in order to process your claim. Currently, without these explanations, we cannot process the other insurance's denial appropriately, and your claim will be denied.

If the other insurance company paid your claim, you do not need to attach the other insurance's Explanation of Benefits. Instead, simply note the payment amount in the "Other Payment" or "Amount Paid" field. You may also bill these claims electronically. The amount will be applied to the claim.

You do not need to send regular Medicare claims to the TPL department's mailbox. When mailing claims to the TPL mailbox (P.O. Box 5838, Helena, MT 59604), please only send claims that need some sort of resolution by the TPL unit. All other claims can be submitted to P.O. Box 8000, Helena, MT 59604.

Recent Publications

The following publications have been sent out since July 1, 2002. To view these publications, visit the Provider Information website (www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm).

07/01/02 Multiple Provider. 2.6% Reduction

- 2.6% reduction to stay into effect through June, 2003. The fees on the new fee schedule (dated 07/02) will reflect the 2.6% reduction.
- No rate increases for RBRVS providers

08/01/02 Prescription Drug Prior Authorization Manual

08/01/02 Inpatient Hospital Manual

08/01/02 Pharmacy Cost Sharing Changes

- $5.00 per prescription cap
- Monthly $25 cost sharing cap
- Exempt clients

09/01/02 Pharmacy Cost Sharing Replacement Page

09/01/02 Multiple Provider Cost Sharing Changes

- Cost sharing changes: $100 inpatient hospital, and $1.00 - 5.00 per visit for other providers.
- Annual cost sharing cap removed
- Exempt providers and services
- Chart of cost sharing amounts

09/26/02 Multiple Provider Update (Physicians, Mid-level practitioners, public health clinics, podiatrists) DME Update:

- Billable DME supples
- Nutrition codes available as of 01/01/03

10/01/02 Multiple Provider 45-day Medicare Crossover Billing Changes

- Providers may not submit Medicare crossover claims to Medicaid before Medicare's 45-day response time
- Exceptions

10/07/02 Multiple Provider Presumptive Eligibility for pregnant women.

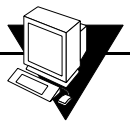
- Covered services
- Determining presumptive eligibility

12/01/02 Physician Related Services (included in this issue of the Claim Jumper):

- Effective 01/01/03, all subsequent surgical procedures, except codes that are modifier 51 exempt or add-on codes, will be reimbursed at 50% of the Medicaid allowed amount.
- Mid-level practitioners must bill for services using their own Medicaid ID number.
- A list of several DME codes that are active for physicians, mid-level practitioners and podiatrists.
- A reminder of the vaccines that are covered under the Vaccines for Children Program (VFC). The codes and descriptions are also included.
- Changes in prior authorization procedures.

01/01/03 Private Duty Nursing Providers PASSPORT approval required (included in this issue of the Claim Jumper)

- Effective February 1, 2003, Private Duty Nursing services requires PASSPORT provider approval.



Provider Information Web Site Update

www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm

Log on to the Provider Information website and get the following current information:

- Provider manuals
- Notices and manual replacement pages
- Fee schedules
- Forms
- Answers to frequently-asked questions
- Upcoming events
- Medicaid statistics
- PASSPORT To Health and Montana Medicaid Claim Jumper newsletters
- Key Contacts for your provider type
- Links to other helpful websites

Montana Medicaid
ACS
P.O. Box 8000
Helena, MT 59604

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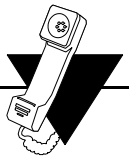

Key Contacts

Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax

Provider Information Website:
http://www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm

FAXBACK (800) 714-0075

Automated Voice Response (800) 714-0060

Point-of-sale help desk (800) 365-4944

PASSPORT (800) 480-6823

Direct Deposit (406) 444-5283

Prior Authorization:

DMEOPS(406) 444-0190
Mountain-Pacific Quality Healthcare Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7951